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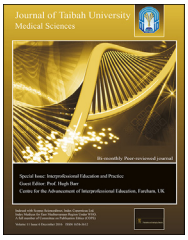

Review Article

Responding as interprofessional educators to the WHO challenge

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الملخص

تقدمت القضية لصالح التعليم المتداخل بين التخصصات في التقارير المتتالية لمنظمة الصحة العالمية بصورة يتردد صداها بقوة أكبر في الدول النامية منها في الدول المتطورة. الدعاوى بأن التعليم المهني الذي يقوده التعلم المتداخل بين التخصصات قد تعالج أزمة القوى العاملة العالمية في الرعاية الصحية هي أكثر إلحاحا في تلك الدول التي يزداد فيها النقص في القوى العاملة الصحية منها في الدول التي يعتبر العرض فيها كافيا.

لا تمثل نتائج البحوث في ما يتعلق بآثار التعليم المتداخل بين التخصصات سوى قمة الجبل الجليدي. تمر الكثير من المبادرات المتعلقة بالتعليم المتداخل بين التخصصات ولم يتم تقييمها أو تسجيلها بالشكل المطلوب، أو ربما رُفعت بصورة مجهولة إلى الحكومات الوطنية، التي على أساسها تعتمد منظمة الصحة العالمية للإخبار عن سياساتها. كما أن النتائج المتعلقة بتأثير التعليم المتداخل بين التخصصات لا يمكن نقلها من البلدان المتقدمة إلى البلدان النامية دون تمحيص، ومن غير أخذ الاختلافات في المضمون والثقافة في الاعتبار.

في هذه الورقة نعود لنستطلع وجهة نظر منظمة الصحة العالمية ونقارنها بالأدلة المتوفرة مع توضيح المفاهيم، آخذين في الاعتبار نسبة انتشار استخدام التعليم المتداخل بين التخصصات كما هو مسجل في الدول النامية والمتطورة. ونستطلع قنوات الاتصال العالمية المشتركة بين التخصصات من خلال المؤتمرات والمجلات والترتيبات الإقليمية للشبكات التي تشرف عليها لجنة التنسيق العالمية. وفي ظل هذه الخلفية، نطرح أسئلة للمربين في مجال التعليم المتداخل بين التخصصات لجس بعض الآثار العملية لتطبيق مقترحات منظمة الصحة العالمية.

الكلمات المفتاحية: الدول المتطو؛ رة؛ الدول النامية؛ التعليم المتداخل بين التخصصات؛ التعليم التحويلي؛ منظمة الصحة العالمية

Abstract

The case for interprofessional education (IPE) advanced in successive World Health Organization (WHO) reports may resonate more strongly in developing than developed countries. Claims made that professional education – galvanised by interprofessional learning – may ameliorate the global workforce crisis in healthcare are more compelling in those countries in which health workforce shortages abound than in those in which supply is deemed to be sufficient.

Research findings regarding the effects of IPE currently represent no more than the tip of an iceberg. Many IPE initiatives go under-evaluated, under-reported and unbeknownst to national governments on whom the WHO relies to inform its policies. Nor can findings regarding the impact of IPE be transferred uncritically from developed to developing countries without considering differences in context and culture.

In this paper we revisit the case made by the WHO, comparing it with available evidence, clarifying concepts, and considering the relative incidence of IPE as reported in developed and developing countries. We review global interprofessional communication channels through conferences, journals and regional arrangements for networking overseen by the World Coordinating Committee. Against that backdrop, we pose questions to interprofessional educators probing some of the practical implications in implementing the WHO propositions.

Keywords: Developed countries; Developing countries; Interprofessional education; Transformative education; World Health Organization

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Revisiting the case

From the outset, the case made by the WHO for IPE was to reform health professions' education from within towards building a stronger workforce, responding more effectively to population and community needs, increasing public appreciation of the health care team and encouraging holistic care[1] to further health for all by the year 2000, enshrined in the Alma Ata Declaration.[2]

The first of two WHO IPE[c] Study Groups[3] grounded the WHO case in the realities of practice. Noting a worldwide trend towards teamwork, its members argued that healthcare workers could perform their responsibilities more efficiently in carefully composed teams of people with various types and degrees of knowledge. The concept of teamwork implied a coordinated delivery of healthcare in the form of preventive, promotive, curative and rehabilitative services. Education should stress ways to help members of healthcare teams understand team responsibilities, the role of each member in carrying out those responsibilities, the extent to which their roles overlap, the need to work together, and the part played by the team in the overall healthcare delivery system. Effectiveness could only be ensured by training members in teams.

Members of the second study group were urged by WHO officials to engage national and international policy makers in discussing strategic issues to demonstrate how IPE and collaborative practice could alleviate the workforce crisis.[4] Reluctant to make assertions that they could not substantiate from their experience, members were nevertheless intent upon persuading policy makers in positions of influence to test the desirability and the feasibility of a package of interprofessional propositions responsive to national and international needs, priorities and opportunities. IPE was presented as a necessary step towards a 'collaborative practice-ready' health workforce. Collaborative practice would strengthen health systems and improve health outcomes. It would maximise the strengths and skills of health workers, enabling them to function at the highest capacity made more necessary by the shortfall in the global workforce.[5]

Much the same proposition was asserted more forcefully in the same year when the independent Lancet Commission called for a global vision and strategy for health professions' education transcending national borders and professional demarcations. Learning needed not only to be formative and informative but also to be transformative and develop leadership for change.

In practice, education had not kept pace with the challenges. Fragmented, outdated and static curricula had produced ill-equipped graduates. The problems were systemic: mismatch of competencies to patient and population needs; poor teamwork; persistent gender stratification of professional status; narrow technical focus without broader contextual understanding; episodic encounters rather than continuous care; predominant hospital orientation at the expense of primary care; quantitative and qualitative imbalances in the professional labour market; and weak leadership to improve health-system performance. Laudable efforts to address these deficiencies had mostly foundered. A thorough and authoritative re-examination was clearly needed: a shared vision and a common strategy for post-secondary education in medicine, nursing and public health reaching beyond the confines of national borders and professional silos.

Transformative learning entailed a shift from fact memorisation to searching, analysis and synthesis of information for decision making; from seeking professional credentials to achieving core competencies for effective teamwork in health systems; and from non-critical adoption of educational models to creative adaptation of global resources to address local priorities. Competency-driven approaches would adapt to rapidly changing local conditions drawing on global resources to promote interprofessional and transprofessional education that would break down professional silos while enhancing collaborative and non-hierarchical relationships in effective teams, exploit the power of information technology for learning, strengthen educational resources with special emphasis on faculty development, and promote a new professionalism that uses competencies as objective criteria for classification of health professionals and that develops a common set of values around social accountability.[6]

Meeting at the same time, communication between the second WHO Study Group and the Lancet Commission was nevertheless conspicuous by its absence. Opportunities were missed to compare and contrast their arguments in common purpose around a single strategy. Synthesis came three years later, when the WHO reaffirmed the essential tenets of IPE,[7] showcased subsequently on its website, to carry forward developments in transformative education (www.whoeducationguidelines.org/).

However, the caution with which the WHO treated the assertions made by the second study group pointed to the need for renewed efforts to assemble evidence regarding the effects of IPE. Researchers were already responding. Findings were being published and collated in successive systematic reviews and scoping exercises. Reeves, Fletcher and Barr et al., in one of the most rigorous and extensive studies,[8] analysed 46 high quality IPE studies of which 26 (57%) were from Europe, 17 (37%) from North America, and 3 (6%) from Australia. They found far more positive than neutral or mixed outcomes, suggesting that learners responded well to IPE. Reciprocal attitudes and perceptions had improved as well as collaborative knowledge and skills. Albeit more limited, there was a growing number of reports of changes in behaviour, organisational practice and benefits to patients.

Clarifying concepts

Interprofessional or transformative education? Beware of false distinctions! IPE, similar to the professional education in which it is embedded,[9] is by definition transformative. It is dedicated to helping students change their attitudes, perceptions and behaviour. Thus, teachers reorient courses towards collaborative learning and practice, and services respond more flexibly to the exigencies of practice. The issue is not whether IPE is transformative, but to what

[c] Referred to at that time as multiprofessional education.

extent, in what directions, and in what ways; not whether it should be supplanted by transformative education, but how its latent capacity to drive change can be released and channelled.

Transformative education becomes interprofessional when it engages the professions in exploring how the changes envisaged will have an impact on their roles, responsibilities and relationships. Work-based interprofessional learning helps participants set aside rivalry and tension liable to generate stress and erect defenses inhibiting change.

Interprofessional educators are, however, the first to recognise that the changes envisaged by the WHO are of a different order from those that they typically pursue. They may look for assurance that their existing commitment to effecting change through IPE is appreciated. They may hold back unless and until they are assured that the healthcare professions (to which most of them belong and owe loyalty) will be invited to join in planning with opportunities to weigh implications not only for their patients but also for themselves. Such engagement will be an extension of everyday collaboration in IPE planning.[10]

How then to square the circle between improving the quality and safety of care, containing costs and deploying personnel to optimum effect? That is the issue. It is enshrined in the interprofessional rubric, the "Triple Aim"[11] in the United States, and mirrored in other countries such as Spain.[12,13] However, extrapolation from the United States (with the highest per capita expenditure on healthcare in the world) to the poorest of the world's developing countries stretches credulity beyond the breaking point.

Estimating incidence

The relative incidence of IPE in developed and developing countries can be estimated from diverse sources. Pioneering initiatives were being reported from the 1960s onwards in Australia,[14] Canada,[14] Sweden,[15] the United Kingdom,[16] the United States,[17] and other developed countries, from which you might infer that IPE is a western phenomenon. However, as early as 1973, the WHO cited initiatives from Algeria, Egypt, Nepal, Pakistan, the Philippines and the Sudan.[1] Other citations from developing countries followed from the Cameroons and the Dominican Republic,[18,19] Fiji and India,[20] Thailand,[3] Lebanon,[21] Colombia[22] and South Africa.[23]

The assumption was nevertheless sustained that IPE was more prevalent in developed than developing countries, an assumption which may seem self-evident but prone to be overstated by summing the relative frequency of citations in peer-reviewed journals and indexes, disregarding their English language bias and many unpublished sources. More dependable information was needed directly from teachers and their institutions, as WHO regional staff appreciated, prompted by Rodger and Hoffman as members of the second WHO IPE Study Group.[5] Together, they elicited 396 responses from 41 countries in all six WHO regions by means of an online questionnaire. Nine out of every ten were from developed countries, two-thirds of them from Canada, the United Kingdom and the United States.[24,d]

While the WHO methodology was an improvement, a risk of bias remained. Developing countries may have been less likely to respond to the survey than developed ones, given the length and complexity of the questionnaire in English only. Additional requests for information lodged on websites may have only reached interprofessional educators in developed countries, whilst Rodger and Hoffman had extensive prior knowledge of IPE in those countries.

The assumed predominance in developed countries was confirmed, however, when the Health Professions Global Network used IPE as the first in a series of two-week web-based debates (http://hpgn.org). A thousand participants from a hundred countries enrolled, of whom 293 contributed from 44 countries. Countries with the greatest number of participants (in declining order) were the United States (219), Australia (102), Canada (75), the United Kingdom (70), India (58), Egypt (45), Switzerland (34), Nigeria (28), Kenya (22), Ireland (21), South Africa (17), Ethiopia (14), New Zealand (14), the Netherlands (14), Portugal (13), Uganda (12), Romania (11), Brazil (11) and Hong Kong (10). While the majority of participants were from developed countries, the majority of contributions came from developing countries.[25] Given this groundswell of interest, we might infer that the difference in interest in IPE, as distinct from incidence, between developed and developing countries is narrowing. My own contacts confirm that it is indeed attracting attention in developing countries, throughout all five continents and reported in at least 73 countries, as part of an interprofessional movement that has been gathering momentum worldwide for half a century.[26,27]

Building bridges

IPE in its formative years typically comprised local, ephemeral, isolated, employment-based grassroots initiatives in response to 'there and then' demands in practice. Opportunities to exchange experience gained momentum as healthcare magazines began to report such initiatives, followed by peer-reviewed professional journals leading to the launch in 1992 of the first journal dedicated to interprofessional education, practice and research, the *Journal of Interprofessional Care* (http://informahealthcare.com/jic), and then others.

These interprofessional journals have concentrated on publishing findings from rigorously conducted research subject to exacting peer-review, thereby enhancing scholarship in interprofessional learning and working, but to the relative exclusion of exploratory, descriptive, and less academic studies including many from poorer developing countries. Subscription rates have also been beyond the pockets of many individuals and institutions in those countries.

[d] The countries (with the number of respondents in parentheses) were: Armenia (1), Australia (26), Bahamas (2), Belgium (1), Canada (98), Cape Verde (1), the Central African Republic (1), China (3), Croatia (2), Denmark (7), Djibouti (1), Egypt (1), Germany (4), Ghana (1), Greece (2), Guinea (1), India (5), Iran (2), Iraq (1), Ireland (23), Japan (2), Jordan (2), Malaysia (1), Malta (2), Mexico (2), Moldova (1), Nepal (1), Norway (6), Pakistan (2), Papua New Guinea (1), Poland (2), Portugal (18), KSA (1), Singapore (1), South Africa (1), Sweden (26), Thailand (2), the United Arab Emirates (1), the United Kingdom (72), the United States (66) and Uruguay (1).

Meanwhile, presentations about interprofessional learning and practice had begun to be included during professional conferences locally, nationally, and internationally, paving the way for the launch in 1997 of the first in an international series of interprofessional conferences under the banner 'All Together Better Health' held since that year in London (twice), Vancouver, Stockholm, Sydney, Kobe, Pittsburgh, and most recently Oxford (www.hls.brookes.ac.uk/atbh8). Opportunities for person-to-person exchange have increased markedly, though more often between educators than practitioners, senior than junior grades, and developed than developing countries.

Notwithstanding these constraints, networking between interprofessional activists is gathering speed in a shrinking world with email, the Internet, Skype, Twitter, Facebook and ever more aids to electronic communication. Progress owes much to the sustained commitment of a cohort of volunteers: addressing some conferences and organising others, penning newsletters, updating websites, conducting reviews and research, publishing papers, editing journals, reviewing manuscripts, and serving on working parties, study groups and committees.

A patchwork of regional interprofessional networks[e] is developing, sharing as their common purpose the promotion of IPE and collaborative practice, but differing in structure, governance, resources and activities. CAIPE – the UK Centre for the Advancement of Interprofessional Education – is the longest-established, with the most formalised constitution and the most extensive international outreach. The (US) National Center for Interprofessional Practice and Education, working with the American Interprofessional Health Collaborative (AIHC), is the best-resourced, enjoying substantial but time-limited funding from Federal Government and major charitable foundations.

Territories overlap but also leave gaps to be filled as new networks are launched, including those in Southern and Central Africa, South America, South East Asia, and the Middle East with North Africa, currently.[f] Regional networks are being complemented by specialists focussing on interprofessional theory, research and development.[g]

The World Coordinating Committee for Interprofessional Education and Collaborative Practice (WCC) (www.atbh.org) represents the regional networks at the international level (including the WHO), facilitates cooperation between them, and supports the biennial, global All Together Better Health Conferences.

Optimising impact

The interprofessional movement is better prepared, equipped and organised today to respond to the WHO call than it was 40 years ago. It is developing interprofessional teamwork wherever it is taking root and fostering a growing appreciation of the importance of collaborative practice as it promotes holistic care. Given the emphasis that they place on learning to work with individuals, interprofessional educators may hesitate to claim that IPE is having a significant impact on population and community needs. Its impact on the workforce may, however, be cumulative as it extends and expands.

IPE initiatives being reported worldwide (exemplified in this special issue) reveal congruity of values, purpose and perception between developed and developing, rich and poor, and eastern and western countries accessing universal communication systems. Congruence is reinforced where universities and their courses in developing countries are accredited or franchised by those in developed countries, or supported by charitable foundations.

Less clear from the literature is how developments reported may be indigenising interprofessional learning and working in their cultural, economic and political context, taking into account implications for the recruitment, preparation and deployment of the workforce.

The poorer the country, the more compelling the WHO challenge becomes. The issues that it highlights, however, are global. They apply, to a greater or lesser degree, wherever professionally qualified workers are in short supply, markedly so where richer countries recruit healthcare workers from poorer countries that can ill afford to lose them.

How then should those of us respond who are interprofessional educators? Are we teaching our students to discriminate in the tasks that they retain personally whilst engaging others appropriately and effectively? Are we helping them to learn how to delegate to paraprofessionals as

[e]

- AfrIPEN – African Interprofessional Education Network (www.facebook.com/afinetwork)
- AIHC – the American Interprofessional Health Collaborative (www.aihc-us.org/)
- AIPPEN – the Australasian Interprofessional Education & Practice Network (www.aippen.net)
- CAIPE – the Centre for the Advancement of Interprofessional Education (www.caipe.org.uk)
- CIHC – the Canadian Interprofessional Health Collaborative (www.cihc.ca/)
- EIPEN – the European Interprofessional Practice and Education Network (www.eipen.eu/)
- JAIPE – the Japan Association for Interprofessional Education (www.jaipe.jp/)
- JIPWEN the Japan Interprofessional Working and Education Network (jipwen.dept.showa.gunma-u.ac.jp/)
- NIPNET – the Nordic Interprofessional Network (www.nipnet.org).

[f] The last of these following the 2015 regional IPE conference in Qatar (www.qu.edu.qa/IPE2015/).

[g] Specialist Interprofessional networks:

- The interprofessional special interest group of the Network: Towards Unity for Health (Network: TUFH) (www.thenetworktufh.org/).
- In-2-Theory (https://www.facebook.com/groups/IN2THEORY/).[28]
- GRIN – the Global Research Interprofessional Network (https://www.facebook.com/grinweb).[29]

they acquire the skills to prepare and supervise them? Are we ensuring that their perceptions of teamwork make room for paraprofessional members collaborating with professional ones?

What opportunities do we create for students to practice and explore career options in rural and other deprived communities desperate for more qualified health professionals? What weight do we accord to preparation for relatively inexpensive models of practice in primary and community care settings, to mobilising voluntary and indigenous resources, to devising strategies to delay or obviate costly admission to hospital and expedite discharge?

Not least, are we ready to look critically at the cost of IPE, especially during the formative planning stage, and ways in which expensive small group learning can be offset where appropriate by less expensive didactic teaching across professional groups?[29] Are we starting to see how IPE may become the change agent to align and rationalise curricula and requirements within and between professional education systems? Are we ready, by way of beginning, to explore how interprofessional learning might be woven into access courses for disadvantaged entrants to broaden horizons and facilitate choices between courses and between careers?

These are just some of the many questions that we need to ask ourselves to respond to the WHO challenge; questions that refer not only to our immediate situation but also to the part that we can play in supporting colleagues near and far attuned to their opportunities and constraints.

Conflict of interest

The author has no conflict of interest to declare.

Author's contribution

HB as sole author grounds this paper in data assembled in his global review of interprofessional education calling on the literature, his liaison with interprofessional activists in may of the countries cited and his role in related international groups.

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